

TBI NEEDS ASSESSMENT-FAMILY/SIGNIFICANT OTHER

Please provide the following demographic information:

1. Where do you live: City _____ County _____
2. Where does your family member/significant other live: City _____
County _____
3. Your relationship to the individual with TBI
 - ☐ Spouse
 - ☐ Sibling
 - ☐ Parent
 - ☐ Child
 - ☐ Significant other
 - ☐ Friend
 - ☐ Care Giver
4. Current age of your family member _____
5. Age when he/she was injured _____
6. How was your family member/significant other injured?
 - ☐ Motorized vehicle *Please check what type of vehicle:*
Car ☐ Truck ☐ Motorcycle ☐ ATV ☐ Other ☐
 - ☐ Bicycle
 - ☐ Bicycle/Auto accident
 - ☐ Pedestrian
 - ☐ Near Drowning
 - ☐ Fall
 - ☐ Assault/Abuse
 - ☐ Firearms/Gun Shot
 - ☐ Medical condition (example: stroke, infection) *describe:* _____
 - ☐ Sports (please identify type of sport): _____
 - ☐ Military
 - ☐ Injured another way (for example: horseback riding, swimming, etc.)
Please describe: _____
7. Has he/she received any of the following services for their traumatic brain injury?
Please check all boxes that apply.
 - ☐ Emergency department care only
 - ☐ Inpatient hospital care
 - ☐ Rehabilitation (inpatient/outpatient)
 - ☐ Non-hospital based residential program (for example: supported living)
 - ☐ Nursing home

- ☐ Mental Health Counseling
- ☐ Other (for example: staying with family/significant other, receiving care at home)

describe: _____

8. Did anyone provide you with information or advise you about services, available for individuals with traumatic brain injury, following your family member/significant other's injury?

- ☐ Yes
- ☐ No

If yes, who provided you with information or advised you?

- ☐ Doctor
- ☐ Social Worker/Case Manager/Counselor
- ☐ Rehabilitation Staff/Vocational Rehabilitation
- ☐ Family/Friends
- ☐ Brain Injury Association of Utah (BIAU)
- ☐ Workers Compensation
- ☐ Other *describe:* _____

Do you feel that professionals listen to the needs of your family member/significant other?

- ☐ Yes
- ☐ No
- ☐ Not Important

School

9. Was your family member/significant other attending school at the time his/her injury occurred?

- ☐ Yes
- ☐ No

10. Was he/she able to attend school after their injury?

- ☐ Yes
- ☐ No

11. Are they currently in school?

- ☐ Yes
- ☐ No

If yes, please check the school they are attending:

- ☐ Elementary
- ☐ Middle/Jr. High School
- ☐ High School
- ☐ College
- ☐ Trade School

- specify* _____
- ☐ Other (Unspecified, private, etc.): _____

12. If your family member/significant other attended school after their injury, did they receive special education services?

- ☐ Did not need special education services
- ☐ Received services and was satisfied
- ☐ Received services and was dissatisfied
- ☐ He/she needed this service, but did not receive it

13. If your family member/significant other's injury occurred after high school did he/she attend school such as a trade school or college?

- ☐ Yes
- ☐ No

If *yes* list school: _____

Employment

14. Was your family member/significant other working/employed when he/she had their injury?

- ☐ Yes
- ☐ No

If *yes*, please check what type of work you did.

- ☐ Professional
- ☐ Manual Labor
- ☐ Clerical
- ☐ Management/Supervisory
- ☐ Business Owner/Operator
- ☐ Food Services
- ☐ Other _____

15. Are they currently working?

- ☐ Yes
- ☐ No

If *yes*, please check what type of work he/she is doing.

- ☐ Professional
- ☐ Trade/Manual Labor
- ☐ Clerical
- ☐ Management/Supervisory
- ☐ Business Owner/Operator
- ☐ Food Services
- ☐ Other (Sales etc.)

16. After they returned to work, did they have a work evaluation?

- ☐ Yes
- ☐ No

If *no*, do you think they need a work evaluation?

- ☐ Yes
- ☐ No

17. If they are not currently working, please check the reason why.

- ☐ Not able to find work
- ☐ Not able to perform the previous job
- ☐ Not able to perform any job
- ☐ Not able to find transportation to work
- ☐ Student
- ☐ Retired
- ☐ Need training
- ☐ Other *describe*: _____

18. What is the longest time your family member/significant other has held a job since the injury?

- ☐ More than 3 years
- ☐ 1-3 years
- ☐ 1 year
- ☐ 6-9 months
- ☐ 3-6 months
- ☐ 1-3 months
- ☐ Less than 1 month

Living Situation

19. Is your family member/significant other receiving supports that are needed to live where he/she wants to live?

- ☐ Yes
- ☐ No
- ☐ Not Important

20. Do you like their current living arrangement?

- ☐ Yes
- ☐ No

If *no*, explain why: _____

Supports

21. Does he/she currently have the transportation they need?

☐ Yes

☐ No

If *no*, explain what the transportation problem is: _____

Treatment

22. Please review the following services and *check all the boxes that apply to your family member/significant other*. For example: He/she received physical therapy services and was satisfied and needs this service again.

Rehabilitation Services	He/she received this service and was satisfied	He/she received this service and was dissatisfied	He/she needs this service	He/she does not need this service
Physical Therapy				
Cognitive Therapy (retraining your brain to improve everyday skills)				
Speech/Language Therapy				
Occupational Therapy				
Physical Therapy				
Vocational Evaluation				
Mental Health Counseling (individual and/or family)				
Assisted/Independent Living Services (residential care not requiring skilled nursing care)				
Case Management/Service Coordination				
Other Services				
Behavioral supports (learning ways to reduce or avoid unwanted behaviors)				
Alcohol or drug treatment (now or in the last 5 years)				
Job Coaching				
Employment (help finding employment)				
Dental				
Vision				
Personal Care				
Homemaking				
Parenting				
Nursing				
Recreation				
Community Skill Training				
Legal Services				

Rehabilitation Services	He/she received this service and was satisfied	He/she received this service and was dissatisfied	He/she needs this service	He/she does not need this service
Money Management (bill paying, budgeting, etc.)				
Transportation				
Assistive Technology (items, equipment, or products that increase, maintain, or improve functional capabilities of individuals)				

23. Has the injury affected any of the following areas of your family member/significant other's life? *(Please check all that apply)*

	No Change	Better	Worse
Marriage			
Education			
Employment			
Income			
Living Situation			
Medical Status			
Parenting			
Mental Health			
Support of friends & family			

If there are other areas of their life that have been affected, please describe:

24. From **your** perspective as the family member/significant other, has the injury affected any of the following areas of **your** life? *(Please check all that apply)*

	No Change	Better	Worse
Marriage			
Education			
Employment			
Income			
Living Situation			
Medical Status			
Parenting			
Mental Health			
Support of friends & family			

25. Describe any other areas of your life that were impacted.

26. What do YOU think needs to be done to improve statewide services and supports for individuals with TBI and their families?

27. What other additional comments or ideas would YOU like the people who plan statewide services and supports to know?

Thank you for your participation